EUDORA MEDICAL

Today's date

WELCOME to your new medical center. We are committed to providing you the best, most comprehensive care possible. We encourage you to ask questions and know that all information you provide is confidential.

ABOUT YOU

First **NAME**	MI	Last name	Date of birth	Age
Ethnicity	Race	Language	Sex born	Sex
EMAIL			**SOCIAL SECURITY NUMBER**	
Home **ADDRESS**		City	State	Zip
Mailing address if different		City	State	Zip
Phone **NUMBER**			Work phone number	

PHARMACY NAME **PHARMACY LOCATION**

NOTIFY IN CASE OF EMERGENCY

Name	Relationship	Phone number	
Address	City	State	Zip

EMPLOYER	Phone number		
Address	City	State	Zip

FINANCIAL RESPONSIBILITY

First **NAME**	MI	Last name	Date of birth	
Home **ADDRESS**		**Ci**ty	State	Zip

PRIMARY INSURANCE

Subscriber name	Subscriber DOB	Subscriber SSN
Group name	Group ID#	Member ID#

SECONDARY INSURANCE

Subscriber name	Subscriber DOB	Subscriber SSN
Group name	Group ID#	Member ID#